Comments on Department HFS 117 Preliminary and Interim Reports and Department Responses

Comment	Department Response
1. It is difficult to explain from my perspective how the actual cost of providing medical records to the patient is at a very reasonable schedule whereas the actual cost of providing medical records to non-patients (with the patient's authority) is at a very unreasonable schedule. In my experience, where patients/plaintiffs give an unqualified authorization, there should be no different labor costs between the two requests. Obviously there is no different non-labor costs. Therefore, the schedules should be the same (at the lower schedule) or much closer. **1**	The Department agrees that the person making the request has no effect on the labor costs associated with the labor and non-labor costs of retrieving the records. The Department's distinction in fee limits between individuals (and their personal representatives) and all other persons is directly and solely driven by the Department's desire to conform the Department's rule requirements to federal HIPAA privacy regulations, which are applicable to most health care providers and which include certain copy fee restrictions. For copying of actual records (as distinguished from preparing explanations or summaries of records), the federal regulations provide at 45 CFR 164.524(c)(4) that individual patients (and, because of 45 CFR 502(g), their personal representatives) can only be charged for the cost of copying (including the cost of supplies for and labor of copying) and postage. A federal guidance document interpreting the HIPAA privacy regulations, published by the HHS Office for Civil Rights in December 2002, explains that, "The fee may not include costs associated with searching for and retrieving the requested information." In contrast, the Wisconsin statute language concerning the HFS 117 rule revision project, at s. 146.83 (3m) (a), allows but does not require such costs to be factored into the fees issued under HFS 117. The Department must structure the HFS 117 fee rules so that they comply with HIPAA. One possible approach to accomplish that would be to have HFS 117 fee maximums that are identical for all requesters, prohibiting a health care provider from charging a search or retrieval cost to any requester. An alternate approach is to have a two-tiered fee system with different fees depending upon whether the requester is the patient or personal representative (who can't be charged for the cost of search/retrieval because of HIPAA) or is some other requester (who can be charged). In the interests of uniformity and ease of administration, the Department proposed a fee structure in which the proposed "per page" fee limit is the same for all requesters. However, requests made by other than an individual would include a flat $12.50 or $15.00 retrieval fee and therefore would be $12.50 to $15.00 higher than the corresponding fee limit for individuals.
2. The fee schedule for records provided to non-patients seems too high. In fact, some of your supporting documents suggest the $21.00/$0.42 per page schedule is the highest cost estimates. Other more reasonable cost estimates were provided. Why weren't those estimates followed? Moreover, if that was an approximation of the actual costs, one must ask the common sense question of how businesses like SourceCorp and FYI Healthserve were able to stay in business, and actually turn a profit, by providing records at the current fee schedule of $8.40 per request or $0.45 per page for the first 50 pages and $0.25 per page for all pages over 50. **1**	The Department initially chose to propose the fee limit resulting from the highest cost estimates, principally for the purposes of illustration, comment and discussion. As the Department noted on page 8 of its preliminary Report, "The Department considers the questions of whether the fee limit includes the added factors of "profit," "subsidization of some (less-than-actual-cost) requesters" and "off-storage costs" to be open and useful subjects for (advisory committee) members' comments." The Department will infer that the commenter does not think the "add-on" factors associated with "profit" and "subsidization" should be included in approximating the actual costs of complying with medical record requests. Ultimately, the Department has chosen to propose fee limits that are about 25% below its highest initial cost estimates. The Department cannot comment on the business practices of commercial entities, however, the Department speculates that requests for which those commercial entities

	receive that level of compensation represent only a fractional proportion of those entities' total requests. The Department further speculates that if, on the other hand, requests for which commercial entities receive the existing HFS 117 level of compensation are relatively more common, the commercial entities might be expected to charge requesters not subject to existing HFS 117 a higher rate in an attempt to compensate for what might be inadequate reimbursement for requests under HFS 117. Cross-subsidization is a common practice in medical care.
3. The most important revision to the proposed rule would be to HFS 117.05. I strongly recommend that the following language be added: Current: "If a patient or personal representative of the patient requests duplicate copies of the patient's medical records…" Revised: If a patient or personal representative of the patient requests uncertified or certified duplicate copies of the patient's medical records. Please have the committee consider this addition. This addition would satisfy a practical issue. **1**	Based on the input of a medical record maintainer on the advisory committee, the Department understands that there are costs associated with certifying medical records (see Department response to comment #25.) Consequently, the Department has proposed a fee limit of $5.00 or $7.50 to reflect an approximation of the actual costs of doing so.
4. The committee should seriously consider returning to this subject in one year to audit and perhaps adjust the fee schedule. This would include having the Legislative Audit Bureau examine and analyze the accounting data for the businesses like SourceCorp and FYI Healthserve to ensure that the fee schedule best approximates the actual costs. **1**	The Department will consider this request. However, the Department's resources are especially constrained and the Department does not have the capacity to request projects to be undertaken by the Legislative Audit Bureau, given that the LAB is in a different branch of state government.
5. We are concerned that the proposed $3.20 per request and .04 per copy for HIPAA purposes is truly reflective of costs - it seems significantly too low. The non-HIPAA request scale seems more reasonable. It is possible that if there are two different cost scales, there could be the potential for most users to claim the lower category and possibly threaten through legal action, complaints, etc., against any medical record producer who does not honor the lower scale as the appropriate amount. **2** When the attorneys and the insurance companies get wind of the possible miniscule rates that patients would pay, they may simply ask the patient to get their own records and therefore straining the fiscal viability of the copy service companies further. **13** A two-tiered fee system creates the potential for abuse. We are vehemently opposed to a single-tiered system if that means the adoption of the lowest fee ($0.20 per page) for all requesters. **2**	The Department agrees that two different fee scales (particularly when one fee limit is a fraction of the other) increases the potential for most requesters to be the individual who is the subject of the records in order to obtain the lower rate. However, that may be an outcome of the two-tiered approach described in federal HIPAA policies and reflected in Department proposed rules. The Department has tried to minimize confusion by proposing a single "per page" The Department believes that whether a two-tiered fee limit will prompt increased legal actions, complaints, etc. is an unknown.
6. The Department should consider utilizing some type of annual medical COLA factor (cost of living adjustment increases like we have in state law for gasoline taxes and noneconomic damage caps in WI) in between the Dept.	The Department considered doing so. However, the legislature directed the Department in s. 146.83 (3m) (b), Stats., to "revise the rules…to account for increases or decreases in actual costs" every ***three*** years. Combined with the likelihood that

reviews called for (every three years, I seem to recall?) **2** The Department failed to include any type of cost of living adjustment for the fees. An equitable way to achieve actual copy costs is to adjust for annual inflation. Over the past several years, inflation has increased in Wisconsin. One example of appropriately increasing costs based on inflation is the cap on non-economic damages. The cap was originally set at $350,000, but has increased to the current level of $410,322. It is anticipated that it will increase another 4% at the next annual adjustment. **2** Many states adjust their fee rates annually to reflect changes in the cost-of-living. Would there be an annual adjustment to the fees proposed in the Report? **4** Although DHFS will review copying costs every three years, that is not enough to ensure that physicians receive the actual cost of copies. The rule should allow for annual adjustments reflecting changes in the consumer price index for all urban consumers, US city average, as determined by the US Department of Labor. The Department would review the fees every three years in accordance with Wis. Stat. sec. 146.83(3m)(b) in addition to the annual inflation adjustments. **2** Annual increases based on CPI seems reasonable and does not seem to contravene the three year fee review required by the Legislature as long as the annual increase is not in lieu of the three year fee review. The use of the annual adjustment for CPI and three-year fee review will more likely attain the desired result of having fees based on true/actual costs. **2**	"automatic" annual adjustments in the fee limits to reflect inflation or deflation would likely result in odd-numbered amounts (e.g., $15.30 if the CPI rose 2%) and consume additional Department staff time, the Department elected not to adjust the fee limits annually. The Department will consider the merits of basing its future inflation adjustments on a solely urban-derived CPI.
7. The fee of $3.20 and $.04 per page for individuals seems unreasonably low. These figures do not seem to accurately represent actual copying costs including supplies, etc. **2** When attorneys become aware that the patient can get record copies at a much lower charge than what they are billed, those requests will be shifted into the patient request category. There has also been a lot of confusion with the Disability Determination Bureau instructing patients to bring record copies to their appointments. This, of course, becomes a redundancy because the DDB later re-requests the same copies anyway. It is not inconceivable that insurance companies will jump on this bandwagon as well. When patients learn that they can obtain their records at little or no cost, patients will be more likely to want to keep a copy of their records at home for little or no reason. **13**	As documented in the data the Department cites in its report, the Department attempted to comply with its statutory directive to "prescribe fees that are based on an approximation of actual costs." However, for reasons described in the Department's response to comment #1, the fee limit for requests made by individuals is much lower. In addition, for the reasons described in the last paragraph of the Department's response to comment #9, the Department has revised its proposed fee limit for requests made by individuals to $0.31 per page.
8. If the rule sets a low fee for individuals, physicians will be placed in the position of rarely, if ever, receiving the true cost of copies. It's not reasonable for the Department to create an impossible situation for physicians and simply	The Department understands the commenter's concern about what she perceives to be the result of a relatively low proposed fee limit. However, the Department's proposal is driven by its desire to comply with both federal requirements expressed in

leave them to deal with the problems. **2**	the HIPAA regulations and the directives in Wisconsin statute. The Department's proposed revision of fee limits for requests from persons who are the subject of the records to $0.31 per page may address the commenter's concerns.
9. We are concerned that DHFS had the opportunity to address the higher cost of copying records on microfiche, but chose not to set a higher fee for records copied from that media. Although, the Department asserts that the percentage of microfiche records is only 12%, that seems significant enough to warrant an increased fee. It seems particularly appropriate to accord the higher fee for microfiche records, since the Department intends to reduce the copy fee as the use of electronic records increases (i.e. reaches 20%). The Department appears to be willing to lower the fees, but not address cost inequities that result from copying from more expensive media. **2**	Since, the Department is striving to propose a fee limit that's as reasonably reflective of actual costs as possible, the Department has reflected the additional costs of copying microfilm/fiche records by incorporating those added costs into its composite cost component-derived fee limits as described below. <u>Average Number of Records Per Request</u> On a related issue, and as discussed below and in the Department's response to comments #17, the Department accepts the opinion that the number of medical records per request should be 25 instead of 20. The 25% higher number would logically correspond to slightly higher numbers of minutes to comply with steps 6 and 7 of Appendix 1. Therefore, the Department has modified its estimate for step 6 of Appendix 1 (screening) to six minutes (instead of five.) However, the Department did not increase its estimate for step 7 (copying) by a full 25% (3 minutes) because of the significant variation in reported estimates for the task of copying records (discussed in footnote "h" to Appendix 1. Instead of increasing the estimated time from 12 minutes to 15 (25%), the Department added only a minute to its original estimate (now 13.) The Department believes that none of the other 12 steps should be appreciably affected by the 25% higher volume of records. Therefore, aside from incorporating recognition of the added time required to copy microfilm/fiche records, the Department's estimates for steps 6 and 7 are now 6 and 13 minutes. <u>Incorporating Microfilm/fiche Into Calculations</u> The only record reproduction cost component that appears to be significantly affected by working with the medium of microfilm/fiche is step 7 (copying.) The Department believes that the associated costs of all other steps/tasks would not be affected by the record medium. If one assumes that the proportion of microfilm/fiche records (reported to be 10-15%) net those of electronic records (reported to be 2-5%) is about **10%**, and the average amount of time to copy a microfilm record is **4 times**[1] the amount for a paper record, one can factor the added labor cost into the aggregate fee limit by multiplying the now 13 minutes attributed to step 7 in the "DHFS Estimates" in Appendix 1 by 4 (because step 7 may be expected to take 4 times longer for a microfilm record) and by assigning a weight of 0.9 to the paper-based estimate of 13 minutes and 0.1 to the microfilm/fiche-based estimate of 52 minutes for step 7 (on the assumption that screening and copying a microfilm/fiche record is 4 times more time-consuming than doing so for a paper record.) The factoring would be as follows: 13 min. x 0.9 (proportion) = 11.7 min.; 52 min. x 0.1 (proportion) = 5.2 min.; 11.7 + 5.2 = 16.9 (rounded to 17 minutes average to reflect the added labor cost associated with microfilm/fiche records. The additional 5 minutes (1 minute due to the increased time associated with copying 25 records instead the original presumption of 20, and 4 minutes attributable to reflecting the added impact of time required to copy microfilm records that are assumed to constitute 10% of the total records copied) would revise the average total required time to be 70 minutes instead of the 64 minutes average

	total required time previously stated in Appendix 1 of the preliminary report. As described in footnote "Q" to Appendix 1, 23 total minutes of aggregate variable labor costs (6 minutes for step 6 and 17 minutes for step 7) at $16.00 per hour equals $6.13; $6.13 divided by a 25-page average equals $0.25 per page (as opposed to the $0.23 currently reported under "DHFS Estimates" for "Labor Cost for Variable Expenses.") Consequently, the total labor costs becomes $12.53 + $0.25 per page. However, the minimum total cost (3rd row from the bottom of Appendix 2) ***remains*** $13.99 + $0.28 per page. The minimum total cost remains the same because, as explained in footnote "o" to Appendix 2, the Department's original estimate of $0.03 per page should have been $0.01. When calculating a fee limit for ***individuals'*** requests, using the revised 17 minutes attributable to the labor associated with copying would increase the allowable cost to $4.53 (for what is now assumed to be an average 25-record request.) To this amount, $0.02 per page is added to reflect copying supplies. However, the Department belatedly recognized that the cost components allowable for requests made by individuals are comprised entirely of ***variable*** costs (labor for copying in step 7 plus the supply costs associated with copying.) Therefore, it is more appropriate to simply exclude a (fixed) "cost per request" based on an assumed average number of records in favor of a simple "per page" cost that reflects the variable copying costs allowable under HIPAA. If so, the fee limit for individuals would be ***$0.20 per page*** ($4.53 divided by a 25-page average for labor equals $0.18; plus $0.02 for supplies.) In its initial proposed rules, however, the Department has elected to suggest a per page fee limit of $0.31 instead of $0.20 in an attempt to respond to the advisory committee's desire for a single fee limit while still recognizing the constraints imposed by HIPAA.
10. The Department proposes to raise the cost of x-rays by $1 (from $4 to $5). That doesn't seem reasonable. The fee of $4 was set approximately 10 years ago. It is difficult to believe that even if you factor only the cost of inflation that the increase is only $1. According to the report, 15 states allow medical record maintainers to charge their actual costs to reproduce x-rays. The Department failed to provide any information regarding what those actual costs tended to be. Only 3 states imposed fees ranging between $1 and $8. Given the data, it is difficult to determine how the Department concluded that a new x-ray fee of $5 is appropriate. The revised x-ray fee does not seem reasonable (why not $8 or $15 or some other number based on data from those states that use actual costs?). **2**	The Department currently has no information regarding what the "actual costs" of reproducing x-rays are in any of the 15 states that allow such charges. In addition, the Department did not consider specifying that record maintainers can charge what they represent to be the actual costs of reproducing x-rays because the Department has been directed in statute to specify fee ***limits*** in administrative rule. Allowing record maintainers to charge whatever they represent as their actual costs is not a ***limit***. The limit of $4.00 for copies of x-ray records was specified in HFS 117 in 1992. In the 11 years since 1992, the national CPI has increased an average of 2.5 percent annually. Based on this inflation factor, what was $4.00 in 1992 becomes $5.25 in 2003. The Department has therefore modified its proposed fee limit to $5.25.
11. The Department weighed the question of whether to establish a lower fee for records copied by clinics, but decided not to do so. I believe that our physicians would agree that the fees that clinics charge for medical records should be at the same level as fees charged by hospitals and ambulatory care settings (not lower). If the Department considers a reduction for clinics in the future, we would vehemently object. **2**	The Department is not currently proposing a lower fee limit for clinics and physician offices, even though an officer of the Wisconsin Health Information Management Association thought the actual costs of clinic and physician office medical record reproduction were lower than that of hospitals.
12. It does not seem reasonable for the Department to define "health care provider records" to include patient billing statements. Wisconsin law requires	The language of s. 908.03 (6m) refers to "health care provider records" without a special definition. Section 146.83 (3m) refers to "patient health care records." Section

the Department to develop copy fees for patient health care records. Wis. Stat. sec. 146.81(4) defines patient health care records. That definition does not specifically include patient billing statements. It seems to me that the Department's creation of a definition for "health care provider records" including patient billing statements exceeds the scope of the Agency's authority. The statute is unambiguous and the Department's rule exceeds the authority given to it by the Legislature. **2** Common Sense dictates that bills are medical records. **10** There is case law in Wisconsin, specifically found in Cruz*, et al. vs. All Saints & MMRA* that dealt with the issue. The Court ruled that patient billing statements are not part of the patient health care records. The Court based the decision on our argument that billing records are not kept in the medical record, nor can they be used to assist in the care of the patient. Most health care providers are careful to keep health care records and business records separate. As the providers are subject to scrutiny from Joint Commission and PRO reviews, they make a deliberate effort to avoid any suggestion that level of care is related to the financial status of the patient. As their medical licenses and ability to receive reimbursement from state and federal programs may be directly affected, the providers are highly sensitive to this issue. We would recommend for the reasons stated above that patient billing statements not be included in the rule changes made by the Department. **12**	146.81 (4) defines "patient health care records" to mean "all records related to the health of a patient prepared by or under the supervision of a health care provider." The language of these statutes neither explicitly includes nor explicitly excludes billing statements, leaving the matter unclear. The Department reviewed the court case in question and found that the only part of the litigation that involved a published court decision was a pre-trial dispute on whether the case was or was not eligible to be a class action. The Department believes that nothing about the case is binding on the Department. Ultimately, the case was settled between the parties without a decision of a court as to the dollar amounts to be charged for copying. As to billing records, the Department could find no mention about the case that addresses the status of billing records. The text of the Court of Appeals published decision concerning class action did not include mention of billing records one way or the other. It is possible that there may have been something in the settlement agreement on that topic, or perhaps the topic may have been mentioned in a ruling by the Racine County Circuit Court in some stage of the lawsuit prior to the settlement. Either way, however, it would not be binding upon the Department in creating the fee rules. The Department can take the settlement information into account along with all other available information in deciding how to structure our fee limits, but the Department is not bound by it. However, in the course of the April 25, 2003 HFS 117 advisory committee meeting, it was asserted that the HIPAA regulations include billing statements under the definition of "designated record." With respect to an individual patient's right to obtain record access and copies, at 45 CFR 164.524(c)(1), the regulation declares, "The covered entity must provide the access requested by individuals, including inspection or obtaining a copy, or both, of the protected health information about them in designated record sets." The HIPAA fee restrictions expressed in 164.524(c)(4) rely upon that concept. "Designated record set" is a special term defined by 45 CFR 164.501 to include the "medical records and billing records" about individuals. Therefore, no matter how the Department defines "health care provider records" in its HFS 117 fee rules, the reality is that health care providers in Wisconsin have to live with HIPAA limits for billing record copying insofar as individual patients and their personal representatives are concerned. In keeping with the advisory committee's desire for a single fee limit, i.e., simplicity, the Department is proposing to include billing statements as a type of "health care provider record."
13. The creation of a fee schedule for patients significantly lower than the standard fee schedule seems problematic. The Department proposes a definition of "personal representative" as anyone who has authority under state law to act on behalf of the patient and qualifies as a personal representative under 42 CFR sec. 164.502(g). There is a typo in the federal rule, I presume	The commenter is correct. The Department erred in its preliminary report when it repeatedly cited "4**2** CFR…" instead of the correct "4**5** CFR…"

the department intended to cite to 45 CFR sec. 164.502(g). **2**	
14. In Wisconsin, a person authorized to act on behalf of the patient includes the parent, guardian or legal custodian of a minor patient, the guardian of an incompetent patient, the personal representative or spouse of a deceased patient, any person authorized in writing by the patient or a health care agent designated by the patient as a principal under chapter 155, if the patient is found to be incapacitated. If there is no surviving spouse of a deceased patient, then person authorized means an adult immediate family member. **2**	The Department's two-tiered fee approach is designed to compel the reduced fees only in categories of situations where HIPAA would require reduced fees. Health care providers have the discretion to voluntarily offer reduced copying fees; however, in order for a requester to be **entitled** to a reduced copying fee under HIPAA, the requester must either be the individual patient or be a person who falls within the HIPAA definition of "personal representative." The federal HIPAA definition of "personal representative" in 45 CFR 164.502(g) is not identical to the Wisconsin definition of "person authorized by the patient" in s. 146.81 (5), and the definition in that Wisconsin statute is not the only Wisconsin standard that could apply to a medical record situation. For example, s. 146.835 notes that parents who have been denied physical placement do not have the traditional parental authority relating to record access. The federal focus is on a person who can make health care decisions on behalf of the patient; in contrast, the Wisconsin definition in s. 146.81 (5) includes someone who has received the patient's consent for access to records. The intent of the proposed HFS 117 definition is to compel the reduced fee only when the requester is someone other than the actual patient who both qualifies to obtain record access under Wisconsin law **and** meets the "personal representative" definition under HIPAA. See also the Department's response to the following comment.
15. The potential number of persons who could receive the records at the incredibly low rate ($3.20) is significant and places an undue burden on physicians. The statutory definition of "person authorized by the patient" might allow attorneys and others to circumvent the rule and obtain copies at the low cost. It is not clear to me that HIPAA (45 CFR sec. 164.502(g)) helps to restrict the potential number of people who might try to get the lower copy fee. **2**	As indicated above, a "personal representative" as defined in HIPAA is not the same thing as the Wisconsin definition of "person authorized by the patient." To maintain consistency with the federal HIPAA regulations and policy interpretations, the Department desires that HFS 117 clearly specify that the lower "individual" fee limit does not apply to an attorney requesting a client's medical records. The Department's position is strongly influenced by federal commentary responding to a comment on page 53254 of the August 14, 2002 Federal Register. In the response, the federal government clarifies that the limited cost components specified under 45 CFR 164.524(c)(4) apply ***only*** to individuals' and individuals' personal representatives' requests for copies of individuals' medical records. It also states that "The fee limitations in 164.524(c)(4) do not apply to any other permissible disclosures by the covered entity, including disclosures that are permitted for treatment, payment or health care operations, disclosures that are based on an individual's authorization that is valid under 164.508, or other disclosures permitted without the individual's authorization as specified in 164.512."
16. The commenter related being billed $20.95 for one page. He pointed out that under the rule language contained in the Department's preliminary report, the same request would have cost him $21.42. He questions whether the Department's proposed fee limit is reasonable. He further asks the hypothetical of whether any individual client might be expected to object to such a fee. **1** We think the proposed fee increases are excessive. **6**	The Department understands that the Department's proposed fee limit seems extremely high. However, everyone must bear the following in mind: 1. The legislature directed the Department to develop fee limits that are "realistic estimates of actual patient record reproduction costs based on an approximation of pertinent costs associated with accomplishing such reproduction." It could have, but did not, ask the Department to simply update the existing HFS 117 rules to reflect inflation. Ample data, referenced in the Department's preliminary report, illustrate that responding to a request for copies of a medical record is not as simple as pulling a

Common sense (not reports prepared by record companies for record companies to guarantee their future income), but Common Sense, dictates that when I request 1-5 pages of records, it doesn't cost more than $5 copy the records then add postage and mail. If there are 100 small requests like this at the same facility, it is totally believable that the same person can copy all of these records and do all the requirements in one day, 8 hours. It takes no time at all to, in effect, copy records of between 5-10 pages for 100 requests (at the facility) by totaling 500 to 1000 pages. I highly doubt they are paying anyone more than $15 per hour to do this, as that would be $30,000 in salary per year. That would probably be the maximium. So, if they get $5.00 per request, at 100 requests, they just were paid $500 and their actual cost was something like .07 cent per page (70.00 at most under my hypothetical) and $120 for the day for the person they hired. They just made $210.00. This amount for the one worker times 250 days in year = $52,500 in profit (and this would more than cover any additional expenses). In the end, this one worker probably processed 25,000 requests of this size in one year. The point is the cost for records is really small and 90% plus of requests are probably under 15 pages. The average is only higher because they count by page and not by actual percentages of individual requests. The record maintainers write the reports and provide the information used for their advantage and not for any other purpose. **10** All medical record fee rules have been clearly created to prevent exorbitant fees being charged to the patients (and their representatives, attorney or otherwise) to obtain records that are in fact their property. Would you want to get a copy of your medical file from your doctor and be charged, let's say, $15 for the request and then $.25 per page. If you had been seeing that doctor for 10 years or more your records charges for those records could be $50 to $100 and there is no way it costs anywhere close to that to copy records. **10**	8x11 or 8x14 inch piece of paper from a file drawer, placing it on a standard photocopier, and punching a button. If it were, calculating an associated fee limit would be much easier, as the bulk of the costs are *variable*. Indeed, as detailed in Appendices 1 and 2 of the Department's preliminary report, most of the costs associated with responding to a request for medical records are *fixed* insofar as they are required regardless of the volume the medical record provider must respond to, whether the request results in one copy being made or 100. However, if committee members or other commenters provide cost information that contradicts that relied upon by the Department in formulating the preliminary fee limits, the Department will review that information and consider revising the preliminary amounts. 2. If a client does not like (or, in the practitioner's opinion, may object to) charges resulting from the application of the HFS 117 fee limits, the practitioner may consider communicating to his or her client the nature of the HFS 117 fee limits and give the client the option of requesting his or her own records, in which case, under the Department's preliminary two-tiered system, would cost the client less. Whether the client thinks such discrepancies to be unreasonable and significant may be expected to vary among clients. 3. The commenters should keep in mind that HFS 117 specifies fee *limits*. Nothing prevents a medical record maintainer from charging less than the lawful fee limit, or not charging anything at all, as is the current practice of some health care providers. To address the commenters' concerns that the Department's previously proposed fee limits for a small number of records were too high, the Department has proposed a lower fee of $12.50 per request plus $0.31 per page for requests of under five pages of records.
17. I believe the average number of pages is closer to 30 pages. I base this on the fact that computerization has increased the amount of information available thereby generating more reports resulting in more pages. In my twenty-two years in health information, I have witnessed the growing of records. I was reviewing the HIPAA Privacy Rule and on page 82273 of the December 2000 preamble it states that the average medical record is 31 pages. **3** AHIOS members believe that the average request results in at least 25 pages. **4** The vast majority of requests are under 10 pages. The average of 25-30 pages is only reached by the few and occasional requests that total several hundred or more pages. These large requests are in reality only a very small percentage of all requests. **10**	The Department believes commenter #3's information is persuasive in its citations and logic. In other words, the Department's believes it is reasonable to assume a somewhat higher amount as an average. In fact, another record copying service reported the average request to be for 23 pages. Therefore, the Department has raised its estimate of the average to 25 records. Doing so adds a minute to the Department's estimate for step #6 in Appendix 1 (screening) of the Department's report. Given the variability is reported estimates for the copying cost component (step #7), the Department has proposed adding only 1 minute (instead of 3) to step #7 due to the increase in average number of records from 20 to 25. However, to reflect the fact that 10% of records are microfilm/fiche, the Department has also added 4 minutes to the estimated average amount of time step #7 takes to complete. That additional amount of time, however, is partially offset by apportioning those imputed added labor costs among more records (now 25.) Therefore, the labor costs for variable expenses has increased only $0.02 per page (and is completely offset by the Department's downward adjustment of its estimate of copier supplies costs (toner and drum replacement) in Appendix 2, as discussed in footnote "o" of Appendix 2.

18. Would the Department consider allowing a separate charge for off-site storage or microfilm processing? **3**	The Department would consider doing so under two assumptions: first, that such storage costs are a reasonable business practice; and second, a persuasive rationale for why the $0.84 a request as an approximation of required "physical space" as a cost component in Appendix 2 is not sufficient reflection of medical record storage. If both of the preceding assumptions are the case, there must also be some reasonable and reasonably accurate way of approximating and reflecting such storage costs.
19. Sales Tax needs to be applied to these requests and I think it should be outlined in the rule as some providers and attorneys were not aware of this until the past few years. **3** The Wisconsin Department of Revenue has ruled that sales tax must be collected for any charges for the provision of copies of patient health care records. Can the rule be modified to clarify that sales tax must be collected? **4** Both 146.83 (3m) (a) and 908 (6m) (d) state that the Department is to establish fees plus applicable tax that are to be the maximum amount that a health care provider may charge. As HIPAA makes no allowance for tax when a provider responds to a patient request, and as a patient will be provided a copy of their records per this federal rule, we are assuming that for patient requests no tax may be assessed. If no tax can be assessed as a result of being compliant with a federal rule, does the Wisconsin Department of Revenue feel that tax has to be paid by the provider of records even though the tax can't be charged? **12**	The Department has added a note to requesters in the rule. However, the substance of the Department's rule itself has no bearing on whether or not sales tax is applicable and nothing the Department says in the rule about the applicability of sales tax affects the current or future reality of such requirements. The applicability of sales tax to a particular transaction is the purview of the Department of Revenue. Therefore it would be inappropriate for the Department to allude to sales tax in the substantive provisions of the rule.
20. The hourly wage for the Department of $16.00 is low. Does this include benefits? $4.00 or 20% is a significant difference when considering 2080 hours of work a year. **3** I highly doubt they are paying anyone more than $15 per hour to do this, as that would be $30,000 in salary per year. **10** In our opinion the Department has determined an extremely low figure for the labor cost of providing a patient with a duplicate set of health care records. The proposed figure of $16 per hour takes into account the labor and benefit cost of the employee, yet does not consider that the entity (be it a hospital or copy service) has to assume other costs to maintain that employee in their position. HIPPA does not limit the labor charge to the hourly pay and benefit amounts of a specific employee, nor does it prohibit such expenses to be considered. There is no business that can survive by charging only for the wages and benefits it pays their employees. Thus, we believe that overhead costs need to be part of the labor charges. **12**	The $16.00 average hourly labor compensation rate was explicitly stated to include consideration of benefits. Moreover, a committee member from Wauwatosa, a suburb of Milwaukee, made the estimate. Whether the assumed salary should be raised to, e.g., to $20, may be a topic for the committee to address. With respect to "overhead" costs," the Department gave explicit recognition to and incorporation of a variety of overhead costs in Appendix 2 of its report. Moreover, generally, the Department's preliminary report estimates were not contested by medical record maintainer representatives.
21. The proposed "per page" portion of the fees are very low. The state of Oklahoma has the lowest fees in the country at 25 cents/page. The numbers	Assuming the commenter is referring to the fee limit of $0.04 per page proposed for requests made by individuals, the Department has revised its approach to specifying

proposed in the Report are comparable and will result in facilities picking up the difference between the uniform fee and the true cost of providing the service. **4**	the fee limit for complying with requests made by individuals, as described in the last paragraph of the Department's response to comment #9. In sum, given that all of the allowable activities that are recognized/allowable for complying with an individual's record request (labor cost for step #7 in Appendix 1 of the preliminary report plus the "paper" and "copier supplies, toner, drum replacement" supply costs associated with the copying in Appendix 2) are ***variable*** costs, the Department believes it is therefore reasonable to specify a fee limit consisting solely of a "per page" fee limit. As also described in the Department's response to comment #9, that fee limit becomes $0.31 per page.
22. The fee proposed for the patient and patient representative requests has not been properly constructed. According to HIPAA, this fee must be "a reasonable cost-based fee provided only the cost of copying and postage" are included. The Report's proposal attempts to meet this test. Unfortunately, the commentary on HIPAA clarifies that only a "per page fee" can be applied to requests from patients and patient representatives. The HIPAA commentary specifically states that "no retrieval, clerical, or administrative fee can be charged." **4**	The Department has for different, but complementary, reasons revised its structure of fee limits for individuals to one that consists solely of a *per page* charge.
23. Can there be clarification that the stated per page fee can be charged for ALL pages provided to the requestor? **4**	Since it was the Department's intent that the per page fee limit applied to all pages provided to the requester, the Department has made that fact explicit in its proposed rules.
24. Which requests for duplicate patient health care records would be covered by the proposed rule? Would all of the following examples be covered? a. Requests from the Bureau of Social Security Disability? b. Requests for certified copies of records? c. Requests from those who are considering underwriting health and/or life insurance? d. Requests from property and casualty insurance companies which are reviewing claims? e. Requests from health insurance companies which are reviewing claims? f. Requests from attorneys who are deciding whether to represent a potential client? g. Requests related to worker's compensation claims? **4**	The Department believes that given the placement and wording of ss. 146.83 (1) and 908.03 (6m), Wis. Stats., the legislature intended the fee limits specified in HFS 117 to apply to all record requests that take place under either one of those statutes, except when a special fee limit is expressed in some other state or federal law for a particular situation. The Department tried to make that point in the language it proposed for HFS 117.02. As indicated in the note to HFS 117.02, the worker's compensation system is an example of a program that has special fee limits, which happen to be imposed by statute under s. 102.13 (2) (b) and which will frequently be encountered by health care providers. Those limits clearly supersede HFS 117. If a requester believes that some special fee is applicable that happens to be lower than the HFS 117 limits, the requester will undoubtedly bring that to the attention of the health care provider.
25. The certification of records requires that extra effort must be expended by the records maintainer. Can a certification fee be established? This certification fee would be in addition to the proposed fees. **4** A certification is really only a statement signed that these are the records requested. There is no special or magic person or supervisor that signs off on these. **10**	In keeping with the Department's attempt to approximate the actual costs of medical record reproduction, if a record maintainer's certifying records entails significantly additional effort, the Department believes that such effort should be reflected in the fee limit. To do so, the Department would need to know the nature of the "extra effort" associated with certifying records. Is it a fixed effort that does not appreciably vary regardless of the number of records involved, or does the effort vary as a function of the number of records involved? If the former, the associated expense would be added to the eventual "per request" component of the fee limit under HFS 117.05 (2).

If an attorney does not specify "certified duplicate health care records" are the fees proposed by the Department applicable? For patient requests, there is only provision for providing duplicate health care records, with no reference made to certifying copies. We agree with the Department that a certification fee needs to be imposed. This fee should be construed as a cost for providing an additional service, and should be charged to the requestor if it is a condition of the request. **12**	If the latter, the associated expense would be added to the eventual "per page" component of the fee limit under HFS 117.05 (2). In either event, the Department would need a reasonable estimate of the time required to certify records. Toward this end, the Department asked several advisory committee record maintainer representatives for information related to these issues. In response, the Department was told that record certifications are performed by management personnel (thereby entailing a higher compensation rate, e.g., $26-30/hour) and that the review, QA and record certification takes an average of 10-20 minutes. Accordingly, the Department proposes adding a fee limit of $5.00 to $7.50 to each request for "certified" records ($0.50 per minute compensation times 10-15 minutes) and has amended HFS 117 to reflect that cost. In response to the question from commenter #12, if an attorney does not specify "certified" records, the proposed $5.00 to $7.50 fee would not apply.
26. Undoubtedly, insurance companies and attorneys will attempt to take advantage of the provision in HIPAA which allows for patients to obtain records at actual product cost. In fact, I have already seen letters from attorneys to their clients outlining the need for them to request the records themselves in order to get cheaper rates. While I feel this a huge loop hole in the Privacy Rule that can be used to usurp state law, I feel that were Wisconsin to establish standards as stated in the preliminary report it would only add credibility to this method of removing the individual states' jurisdiction on medical record fees for legal and insurance purposes. My reason for this concern is clearly self serving, yet I feel quite valid nonetheless. Beyond my position in this industry and environment the main two reasons this must be avoided at all cost is two fold. One, the Privacy Rule clearly states that the patient or patients' representative can receive records upon payment based on actual product cost. However, the Rule also clearly defines what a patients' representative is, neither attorney nor insurance company is included in this definition. Allowing for attorneys and insurance companies to be the ultimate recipient of medical records in which HIPAA mandated patient rates are charged was not the intention of this provision, nor should any state create standards by which this action is made to be a simpler process. Secondly, making the assumption attorneys et al will use this provision to obtain records (and they will as evidence by the letter from the attorney to his client which we obtained) the release of information industry will not only be devastated it will be destroyed. Companies such as ours will not only be unable to operate of a profit, we will be unable to pay our employees and will go out of business. While some may see this as a good thing, rest assured the medical facilities would then be forced to assume this cost and it would be equally as destructive for them. In short, this would disrupt the rather smooth	Commenter #5 raises an interesting point. However, the Department has no control over the structure of the federal HIPAA provisions. Nothing in the HIPAA regulations prevents a patient or personal representative from obtaining a copy of records and then providing that copy to someone else. The HIPAA regulations do not limit the purpose of the patient or personal representative in seeking records. Accordingly, the Department lacks authority to specify in the HFS 117 rules that a patient or personal representative is eligible for the lower fee only if he or she keeps the records for personal use.

flow as it exists today in the release of information industry. Before copy services existed, medical providers could not meet release of information demands resulting in huge backlogs. Sure, if today's provisions eliminate my industry it would only be a matter of time before medical providers face a similar situation and routinely violate HIPAA standards for turnaround time. This would just lead the cycle back to the need for ROI providers. It need not get to that point. This being said, what is the solution? I feel it is quite simple. One, I hope that there will be reversal or clarification of this provision at the federal level. Such a thing would of course render my current concerns with your department moot. Two, were this not to occur, the department must be very careful in the wording used in the code. Instead of stating patients must only pay x amount for any purpose and letting the chips fall where they may, I feel it would be prudent to include language that would specify that those rates only apply for strictly personal purposes, such as keeping a personal file or review of one's record. The rule should state that these reduced rates do not apply for legal or insurance purposes. In fact, rather than basing the fees on who the requestor is, the fees should be based on the purpose for the request. This would be quite practical and easily discernable as a HIPAA requirement for authorizations includes that the purpose for the request must be given (on these authorizations there are areas to check insurance, legal, personal, medical care, etc). While the patient could still be misleading and say personal when its not (this would be impossible to enforce), in all likelihood they would be honest and indicate the actual purpose. This being the case, a rule based on the purpose of request rather than who the requestor is I feel would more closely resemble a standard as intended by HIPAA rules. While there is no silver bullet as long as this HIPAA provision remains unchanged, I feel this would be the most fair and accurate decision to make at the state level. Of course people will still try to find loopholes; attorneys will have patients request records and indicate personal purpose even as they do today; but why should we create a rule which simply makes this loop hole larger? **5**	
I would like to see the language that excludes lawyers from the same fees under HIPAA or anywhere else. Lawyers by their very fee agreement and by definition are the personal representative of their clients and I don't see how our request can truly, legitimately and more importantly, legally, be excluded as not being a personal representative. We in fact stand in our client's stead and by allowing us the same rights as our client you would not be in violation of HIPAA. **10**	See the Department's response to comment #14 and comment #15, elaborating on what constitutes a "personal representative" under HIPAA.
27. The proposed fee structure creates confusion and raises the question: "What is the actual cost of duplicating medical records?" Is it $3.20 plus 4¢	The Department's initial estimated approximations of actual costs of duplicating medical records are stated in the last three rows of column three in Appendix 2. The

per page or $21.00 plus 42¢ per page? **6**	lowest estimate proposed was $13.99 + $0.28 per page. That estimate did not reflect either "profit" or ""subsidy." A fee limit of $15.38 + $0.31 per page reflected incorporating a 10% profit. The fee limit of $20.99 + $0.42 per page reflected incorporating both a 10% profit and 40% subsidy. A fourth (unstated in Appendix 2) option was $19.59 + $0.39 per page, which reflected incorporating only the 40% subsidy. Following discussion of these factors at the April 25th advisory committee meeting, the Department elected to incorporate into the fee limit recognition of a small profit only.
28. The proposed increases for non-patients are not consistent with the current rate structure and represent an unwarranted increase in fees. We recommend DHFS review and compare any fee structure with cost of living increases for the last decade. We propose a fee structure similar to the current fee structure; the greater of a set amount or a cost per page, which does not contradict HIPAA regulations or include a retrieval fee charge. **6**	The Department understands that the proposed fee limit structure is not the same as the current rate structure. At no point did the Department accept and state as a given that revisions to HFS 117 must be consistent with the structure in existing HFS 117. Neither did the Department understand that its statutory directive or proposed approach be that of simply revising the existing HFS 117 fee structure and limits to reflect inflationary increases in the cost of living over the past 11 years. Adhering to the approach of approximating actual costs suggests developing or using a cost model that approximates current reality. The Department compared the fee structure and limits of other states and found that most states use some combination of fee limit per request, fee limit per page, or both. The Department's proposal has similar characteristics. With respect to HIPAA's impact, the statute language enacted in Wisconsin contains explicit language in s. 146.83 (3m) (a) indicating that the Department's rules ***may*** consider the cost of retrieval of records. That is, the Wisconsin legislature endorsed (although did not require) including such costs in the fee limit. However, HIPAA prohibits charging the individual patient or personal representative for that activity. If the Department were to specify a single fee structure, in order to comply with HIPAA, that fee would of necessity have to prohibit including any cost of retrieval in the calculation. The Department could indeed do that and still be in compliance with s. 146.83 (3m), but it would appear to be inconsistent with the legislative endorsement of charging for the cost of retrieval. That leaves the Department with a two-tiered system, which, following the April 25th advisory committee meeting, the Department elected to simplify by proposing a uniform $0.31 per page fee limit.
29. We believe the legislation's goal was to create one fee structure for all requests for medical records, not establish a two-tiered fee structure for different parties. It was also the intent of the legislation to try and rein in costs associated with paying for duplicate medical records. **6** In the 2001-03 Budget Repair Bill, I successfully inserted a provision requiring the Department of Health and Family Services to promulgate a rule setting forth uniform fees medical record providers may charge medical record requestors. The proposal came about as a result of a constituent from Phillips who told me how much health care record providers were charging for photocopies of medical records he requested on his client's behalf. People were routinely charged $20 for a one-page record. Furthermore, I was informed that under HFS 117 fees couldn't exceed the greater of $8.40 per	Section 908.03 (6m) (d) of the statutes directs the Department to "by rule, prescribe uniform fees that are based on an approximation of actual costs. The fees, plus applicable tax, are the maximum amount that a health care provider may charge for certified duplicate patient health care records. The rule shall also allow the health care provider to charge for actual postage or other actual delivery costs. For duplicate patient health care records and duplicate X–ray reports or the referral of X–rays to another health care provider that are requested before commencement of an action, s. 146.83 (1) (b) and (c) and (3m) applies." The wording of the first sentence of paragraph (d), stated in part above, is the only reference to "uniform" fees in either 908.03 (6m) or 146.83. Nothing in that language prohibits having more than one fee. In fact, the language refers to "fees" rather than "fee." What is clear is that the Department is expected to create standards establishing maximum fee limits so that the decision on maximums will not be left up

request or 45 cents per record page for the first 50 pages and 25 cents per record page for the remaining pages and $4 for each X-ray copy. However, HFS 117 only applied to medical records requested as part of a commenced court action. This did not seem fair to me. Patients should not be charged such a high price for copies of their medical records regardless if they are requesting the records themselves or someone is requesting them on their behalf. The intent of my proposal was to stop the exorbitant rates charged by medical record providers and have a single uniform fee system. Thus, I drafted legislation requiring the Department to come up with a uniform fee structure that represented the maximum amount a medical record provider could charge a requestor based on an approximation of actual costs. **8** I would like to make it clear that at no time was a two tiered fee structure considered. We felt by using word "uniform" the Department would come up with a single uniform fee structure that applied to all requesters. It was never the intent of the legislation to create different tiers of requestors each with their own uniform fee structure. **9**	to the particular health care provider. One might argue that a single fee would necessarily have to exclude the cost of record retrieval in order to be HIPAA compliant with regard to requesters who happen to be the individual patients or their personal representatives. However, excluding record retrieval costs conflicts with section 146.83 (3m) (a) 2. of the statutes, which explicitly authorizes the Department to consider the cost of retrieval as a recognized record duplication cost component. The only way to honor that language and still achieve HIPAA compliance is by means of more than one fee limit. A two-tiered fee system actually honors the factors articulated by the legislature in s. 146.83 (3m) (a). The Department intends to submit to the legislature a uniform, single record duplication fee limit that applies not only to contested case circumstances, but with one exception, all other circumstances also in which other applicable laws do not govern. The one exception is a fee limit for requests made by individuals or their personal representatives. In those cases, the Department has proposed a $0.31 per page fee limit in recognition of federal law that constrains the type of actual costs that record maintainers can charge an individual for. The Department's proposal to specify two uniform fee limits is the Department's attempt to achieve compliance with HIPAA while still giving effect to as much of the Wisconsin statute as possible. The HIPAA federal law restricts the allowable costs charged to individuals to just the copying supplies and labor. That law is applicable to all "covered entities," which includes health plans and most health care providers in Wisconsin. The Wisconsin laws (stated above) direct the Department to develop fee limits for record requests that must be a reasonable approximation of (all) actual record duplication costs. The Department's proposed HFS 117 attempts to "marry" the federal and Wisconsin law requirements. With that said, everyone should bear in mind that what the Department is proposing as HFS 117 is not necessarily what will become law. The rule could change in subsequent stages of this rule promulgation. Those changes may be made pursuant to review of the proposed rules by the Legislative Council Rules Clearinghouse, a public hearing process with further opportunity for public comment, and the possibility of action by the legislature itself.
30. The proposed rule creates confusion. The two-tiered fee structure proposed presents a myriad of concerns. For example, in many cases, whether it is dealing with a car accident or social security disability requests, a person comes to a law office and signs a medical authorization request. The authorization form is sent to the medical provider along with a letter from the attorney requesting the medical records. Who is requesting the records, the patient, who authorizes the release or the attorney who wrote the letter? It is very important to remember that it is the patient who ultimately pays for the records. The attorneys do not pay for the cost of getting the records. The cost is passed on to the client/patient. Why in one circumstance does the patient pay $3.20 plus 4¢ a page, but in another circumstance the patient pays $21.00 plus 42¢ a page? Under the proposed scenario what happens if the patient sends a letter and asks for the records to be sent to an attorney's office; which party is requesting the records, the patient or attorney? What happens if the	The requester is the person or entity that transmits the request to the health care provider. If the patient signs a form authorizing an attorney to obtain records, gives the signed form to the attorney, and the attorney then sends the authorization to the health care provider along with a request that the health care provider give the attorney the records, the requester is the attorney. If the patient makes the request directly to the health care provider, the requester is the patient. While this may be problematic, the Department believes it is the inevitable result of the HIPAA language. The Department must attempt to comply with the language.

medical records are requested by the patient who asks that they be sent to an attorney's office and the attorney pays for the copies, who "requested" the records? **6**	
31. A concern is the limitation on the definition of "personal representative." Wisconsin has specifically enacted a Power of Attorney for Health Care statute (chapter 155.) The person is empowered to act on behalf of an incapacitated individual. Under the current fee proposal, would the power of attorney for health care have to pay $21 plus 42¢ a page for the medical records of the incapacitated person? **6**	A health care agent acting under an activated power of attorney for health care document qualifies for the reduced fee if the health care agent is the records requester. That person has explicit authority under Wisconsin statutes in ch. 155 to make health care decisions on behalf of the patient and access health records of the patient, and also falls within the federal definition of "personal representative" in the HIPAA regulations. If a health care agent merely signs an authorization form allowing disclosure of records to a third party and it is the third party who is the records requester, then the third party record requester does not qualify for the reduced fee.
32. We certainly object to the inclusion of profit and subsidization costs in the proposed fee structure. Why should a profit-making business be subsidized and guaranteed a profit? We do not believe profit and subsidization are part of the actual cost of duplicating medical records. It is the company's business decision to charge less for medical records to certain groups or businesses. We believe this practice has contributed to the current fee schism, charging little or nothing to some groups or individuals while overcharging others, and why members of our organizations are upset by current charges for medical records. **6** I think the law is quite clear that the charges must be cost based. The law never assumed there would be huge records companies maintaining records, and in effect becoming very rich off holding and copying records. The law says "cost". **10** **Note:** The following comments are from Ann Anderson of the Department's Office of Program Review and Audit (OPRA.) A 10% additional increment on estimated actual costs for profit appears to be reasonable. A precedence is in Wis Stat. 46.036 and the Department's Allowable Cost Policy Manual, which allow about a 10% excess revenue or profit for services paid for by Department funds when the payments are based on or limited by the actual allowable costs of providing the services. A 40% increment to subsidize customers who do not pay for the copy service or who pay less than the established rate for the service does not appear to be reasonable. A health care facility has no obligation to provide copies to individuals who cannot pay, and requiring payment before making the copies would avoid the problem of purchaser not paying for services that they have received." If a facility has a contract with the medical record requester purchaser, the facility may negotiate a higher rate for the copy service. If the copies are needed as part of government oversight of a program that the medical record maintainer facility participates in, the facility has made a choice	The fee limits in the Department's initial proposed rules only incorporate recognition of a small profit factor. If the legislature does not agree that a modest "profit" is not an appropriate element of an organization's actual cost of producing a product or providing a service, they will have the opportunity to direct the Department to modify its proposed rule accordingly.

to participate in that government program, and other purchasers should not be expected to subsidize this choice. However, the health care industry has a longstanding practice of charging higher rates to some consumers of services to make up for shortfalls in government payments for other consumers. Nevertheless, the statutes authorizing establishing rates for copies specifically refer to "reasonable costs" and "approximation of actual costs." It does not appear reasonable to inflate the rate for copies made for some purchasers to make up for a loss associated with copies made in administration of government programs. **11** 2001 Wisconsin Act 109 directed your Department to prescribe copying fees that are based on an approximation of actual costs incurred by entities producing the copies. To allow recognition of "profit" and "subsidization" factors in the HFS 117 fee limits would go beyond the legislative directive. An approximation of actual costs incurred cannot be construed to include profit and subsidization factors. Inclusion of such factors into the fee limits would be unconstitutional. Does not it make sense to do it right from the beginning by not including such factors into the fee limits? **14** To the extent that physicians have costs associated with records because of added factors, we agree it would be reasonable to try to add some of those costs into the fee schedule. In the chart that outlines the comments to the proposed rule, the Department questions the feasibility of considering the question of whether the fee limit should include added factors of "profit," "subsidization of some (less than actual-cost) requesters" and off storage costs." It seems that it would be reasonable to increase the fee limit to incorporate some of those costs, if at all possible. **2**	
33. Records requests for persons seeking eligibility for means-tested governmental benefit programs seem to fall somewhere between the "patient/patient's personal representative" and "other entities" requesting records. We believe the rules need to provide a third category with capability for alternate fee structures for federal and federal/state eligibility programs where the fee schedule is not in law, but rather is driven by federal government budgeting oversight. If this is not feasible, we would recommend the applicability of the rule not include records requests for government program eligibility determinations. We would also suggest that the rule not dictate for the disability program the process for the records request as we must follow federal program policy in this regard. **7**	The two-tiered fee structure is the result of the federal HIPAA requirements. HIPAA does not give a special copy fee break to anyone other than the individual patient or "personal representative," as defined in the HIPAA regulations. If another state or federal law applicable to a variety of record request contains its own fee limits, those fee limits would supersede the proposed HFS 117 fee limits, as is indicated in HFS 117.02. The health care provider can also reduce or waive fees pursuant to a contract with a record requester, or simply because of the health care provider's own volition. The HFS 117 rules are ***maximum*** fees, not ***minimum*** fees. There are no procedures expressed in the HFS 117 rules other than the obvious need for the requester to appropriately articulate whose records are being sought and to assure the health care provider that the requester qualifies to obtain them.
34. While the current record keeping by electronic files is a relatively low percentage, consideration should be given to more than just electronic record	The Department considered including electronic disclosures as a fee category if specific details could have been provided for appropriate review of the situation.

files. The Social Security Administration is rapidly moving to electronic record claims files. We are actively working with record sources on electronic record creation as well as electronic transmission from paper records. One major release of information company with contracts with hundreds of medical facilities nationwide already offers us this service through a web-based access, and we believe more of these companies will move to this method during the next year. We believe the rules should now reflect the efficiencies and potential cost differences in these situations rather than waiting for the update review in three years. **7**	However, through April 30, 2003, the Department did not receive further information. The fee rules are intended to be based upon actual cost information and cannot speculate what might happen at some unknown future occasion. The Department will review the rules more frequently than every three years if circumstances warrant a shorter review period.
35….great credence has been given to Rose Dunn and the information from two of her articles, *Copying Records: How Much Does It Really Cost?* (published May 4, 1992 in *For the Record)* and *Copying Records the Saga Continues* (published April 7, 1997 in *For the Record).* We would like to point out that neither article had information taken from an actual health care provider setting. Of all the information submitted to the HFS 117 Advisory Committee to date, only MMRA has submitted any *actual* figures as to length of time and costs associated with providing a duplicate set of health care records. These figures came from our own time study and from data supplied by several of our clients. **12**	The Department appreciates the time study data provided by the commenter and presented the data in its preliminary and subsequent reports. With limited time and limited resources, the Department attempted to collect a wide variety of useful and pertinent information about the amount of time and money expended in responding to requests for duplicating medical records. The Dunn articles were one of several sources the Department used to derive its "approximations of actual costs" estimates. As one might expect, all of the Department's sources were supplied by medical record maintainers.
36. Our own practical experience is that late payments and bad debt expense have to be factored into our fee schedule. The Department seems to have only considered initial costs of production in its fee determination. **12**	The Department did not incorporate recognition for bad debt and late payments (estimated by Dunn to be about 10%), principally because the Department was uncertain whether and to what extent medical record maintainer billing practices currently are already structured to minimize bad debts and late payments.

Footnote

[1] Dunn reported in her 1997 article that copying microfilm took 4-5 times longer than copying paper documents. Two medical record maintainers estimated that copying microfilm took 3-4 times longer. A representative of entities that reproduce medical records estimated "at least 4 times" longer. The Department is using an estimate of 4 times longer.

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